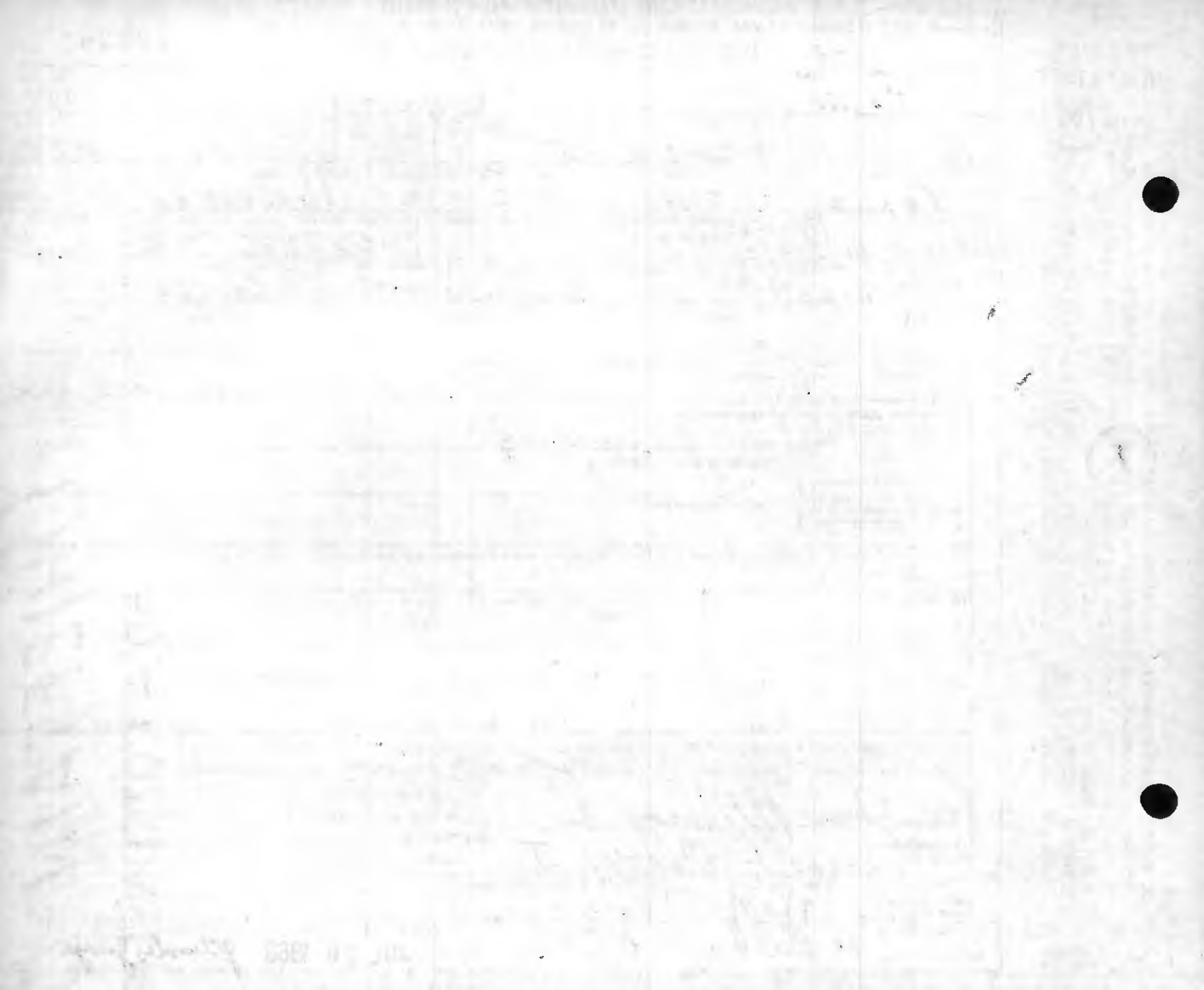


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10826	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <u>Clyde</u>			Middle <u>L.</u>			Last <u>Bonner</u>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>7</u> Day <u>26</u> Year <u>1968</u>		2b. HOUR <u>7:30 A.M.</u>
3. SEX <u>M</u>	4. RACE <u>CAUC.</u>	5. DATE OF BIRTH <u>9-2-02</u>	6. AGE (In years last birthday) <u>65</u> YRS.	IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS HOURS <u></u> MIN. <u></u>		2c. DATE PRONOUNCED DEAD Month <u>7</u> Day <u>26</u> Year <u>1968</u>		2d. HOUR <u>8:45 A.M.</u>	
7a. BIRTHPLACE (State or foreign country) <u>TEXAS</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>WORCESTER Co., Md.</u>					
10. CITY OR TOWN OF DEATH <u>BERLIN MD. (GUEST)</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>ASSATEAGUE</u>				12a. USUAL OCCUPATION (Kind of work done during part of working life, even if retired.) <u>SEAMAN</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>SHIPPING</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>TEXAS</u>		13b. COUNTY <u>LAKE JACKSON</u>		13c. CITY OR TOWN <u>LAKE JACKSON</u>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <u>216 LAUREL ST.</u>			
14. FATHER'S NAME First <u>unknown</u> Middle <u></u> Last <u></u>			15. MOTHER'S MAIDEN NAME First <u>unknown</u> Middle <u></u> Last <u></u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>MRS. CLYDE L. BONNER, SAME ADDR.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>DROWNING</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u></u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>8321</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>730</u> <u>XMC</u> <u>7-26</u> <u>1968</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Jumped off boat, drowned in surf</u>							
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Boat</u>		21f. LOCATION Street or R.F.D. No. <u>Assateague Island</u>		City or Town <u>Worcester</u>		County <u>Md.</u>		State <u></u>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James H. Murray, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <u>7-26-68</u>					
EXAMINER'S NAME (Type) <u>JAMES H. MURRAY, JR.</u>		ADDRESS (Street, city, town, or county) <u>Forest Lawn Cem. P.O. Box 100, Berlin, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>7/30/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FOREST LAWN CEM.</u>		23d. LOCATION (City or Town) <u>BERGAMONT</u>		(County) <u>JEFF. TEXAS</u>		(State) <u></u>	
24. FUNERAL DIRECTOR <u>Anna R. Burbage</u>		ADDRESS <u>Berlin, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 30 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) CLARA J. HENDERSON						2a. DATE OF DEATH Month July Day 31 , Year 1968			2b. HOUR 11:30 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 15, 1908		6. AGE (In years last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Worcester Md.					
10. CITY OR TOWN OF DEATH Pocomoke City			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 911 Walnut Street			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY --		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 911 Walnut Street		
14. FATHER'S NAME First Middle Last Lloyd Will Jones				15. MOTHER'S MAIDEN NAME First Middle Last Etta Rebecca Slocomb							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Fred U. Henderson, Pocomoke City, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension, Cardiac DUE TO, OR AS A CONSEQUENCE OF (c) Vascular Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443 X Arteriosclerosis, generalized											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 16, 1958 , to July 31, 1968 , that (I) (we) last saw the deceased alive on July 31, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles W. Trader M.D.						DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Aug. 2, 1968	
22d. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D., 302						22e. ADDRESS Market St., Pocomoke, Maryland.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-3-1968		23c. NAME OF CEMETERY Creek Presbyterian				23d. LOCATION (City or Town) (County) (State) Pocomoke City-Wor.-Md.			
24. FUNERAL DIRECTOR Robert H. Watson						ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR DATE AUG 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

NEW YORK, N.Y.

SEPTEMBER 11

1870

SIR,

SIR,

SIR,

DEAR SIR,

DEAR SIR,

DEAR SIR,

I have the honor

to acknowledge

the receipt of

your letter of the

10th inst.

and in reply to

inform you that

the same has been

forwarded to the

proper authorities

for their consideration

and I am, Sir, very

truly, Sir, your

obedient servant,

J. H. B.

J. H. B.

Very respectfully,

J. H. B.

J. H. B.

J. H. B.

Yours, Sir, very

truly, Sir, your

obedient servant,

J. H. B.

Very respectfully,

J. H. B.

J. H. B.

J. H. B.

Yours, Sir, very

truly, Sir, your

obedient servant,

J. H. B.

Very respectfully,

J. H. B.

J. H. B.

J. H. B.

Yours, Sir, very

truly, Sir, your

obedient servant,

J. H. B.

Very respectfully,

J. H. B.

J. H. B.

J. H. B.

Yours, Sir, very

truly, Sir, your

obedient servant,

J. H. B.

Very respectfully,

J. H. B.

J. H. B.

J. H. B.

Yours, Sir, very

truly, Sir, your

obedient servant,

J. H. B.

Very respectfully,

J. H. B.

J. H. B.

J. H. B.

Yours, Sir, very

truly, Sir, your

obedient servant,

J. H. B.

Very respectfully,

J. H. B.

J. H. B.

J. H. B.

Yours, Sir, very

truly, Sir, your

obedient servant,

J. H. B.

Very respectfully,

J. H. B.

J. H. B.

J. H. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

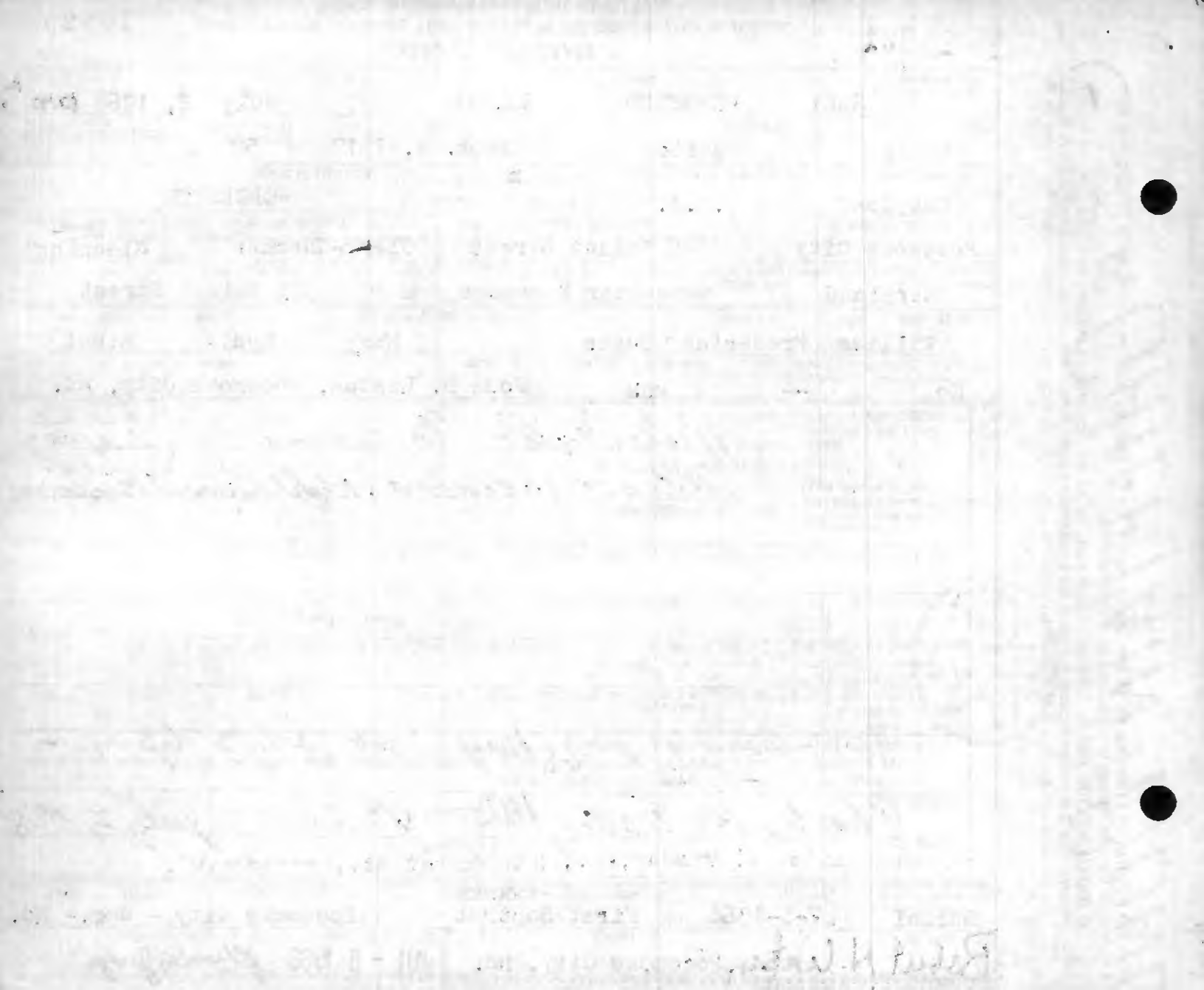
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove paraffin papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR	
Arthur R. Hickman						July 4 1968			11A M	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male	Negro		June 30, 1876			92 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
South Carolina		USA				Worcester Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Snow Hill			RFD # 1			Plasterer		Home Build.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Worcester		Snow Hill					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Favour Hickman			UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			Unknown		Sallie Johnson, Snow Hill, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCT</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GENERALIZED ARTERIO SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 4201									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Hrs 7 YRS many yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Sept 1967, to July 4, 1968, that (I) (we)† saw the deceased alive on July 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Robert C. La Mar</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 7/5/68					
22d. PHYSICIAN'S NAME (Type) Robert C. La Mar, M. D.					22e. ADDRESS 104 N. Bay Street, Snow Hill, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		July 7 1968		Zion Hill Baptist		Littleton N.C.				
24. FUNERAL DIRECTOR <u>Thomas P. Harris</u> ADDRESS <u>Snow Hill, Md.</u>					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
108221 CERTIFICATE OF DEATH 108229									
1. DECEASED-NAME (Type or print) First Middle Last MARY WINIFRED LINTON					2a. DATE OF DEATH Month Day Year July 2, 1968			2b. HOUR M. 10:40	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 4, 1917		6. AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WORCESTER Md.			
10. CITY OR TOWN OF DEATH Pocomoke City		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 505 Walnut Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk-Checker		12b. KIND OF BUSINESS OR INDUSTRY Dry-Cleaning			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 505 Walnut Street	
14. FATHER'S NAME First Middle Last William Frederick Burke					15. MOTHER'S MAIDEN NAME First Middle Last Mary Lydia Stant				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. unk		17. INFORMANT Address John B. Linton, Pocomoke City, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma, Right Breast DUE TO, OR AS A CONSEQUENCE OF (c) 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years approx. 13 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from May , 19 66 , to July 2 , 19 68 , that (I) (we) last saw the deceased alive on July 2 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles W. Trader, MD					22c. DATE SIGNED July 2, 1968		22d. PHYSICIAN'S NAME (Type) Charles W. Trader, MD		
22e. ADDRESS 302 Market St., Pocomoke, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-5-1968		23c. NAME OF CEMETERY First Baptist		23d. LOCATION (City or Town) (County) (State) Pocomoke City - Wor.- Md.			
24. FUNERAL DIRECTOR ADDRESS Robert H. Watson					25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



10822

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		c. LENGTH OF STAY IN 1b <u>All Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Rt #3 Box 162</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Lockwood</u> Last <u>Lockwood</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 1, 1900</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Berlin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Lockwood</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Bowens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Harry Lockwood</u>		Address <u>Garrisonville, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocarditis</u> 428X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>✓</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4222		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-20-68</u> to <u>7-22-68</u> , that (I) (we) last saw the deceased alive on <u>7-20-68</u> , and that death occurred at <u>4:50 PM</u> , from causes and on the date stated above.		19 <u>68</u> <u>7-22-1968</u>	
22a. SIGNATURE <u>Clifford E. Schott</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Clifford E. Schott M.D.</u>		22d. ADDRESS <u>Berlin, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-25-68</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>William A.M.E.</u>		23d. LOCATION (City or Town) (County) (State) <u>Newark Wm Md</u>	
24. FUNERAL DIRECTOR <u>Lois B. Jolley</u>		25a. REC'D BY REGISTRAR <u>J. Charles J. Jolley</u>	
ADDRESS <u>Jersey Rd #2</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles J. Jolley</u>	
BALTIMORE, MD.		DATE <u>JUL 29 1968</u>	

[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-443. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR		
ELIZABETH ELLEN MITCHELL						Month Day Year		1968 11 30		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		
Female	White	9-19-1912	55 YRS					Month Day Year 1968 11 30		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Virginia		U.S.A.				WORCESTER				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Pocomoke City			Market Street			Manager		Food Service		
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland			Worcester		Pocomoke		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		704 Market Street	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Stephen Mason Payne			Addie V. Isdell							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
no			217-28-2761		Walter P. Mitchell, Pocomoke, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>									Minutes	
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4201										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>Melanoma, Left Pelvic Area with Probable Metastasis</u>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH			HOUR A.M. P.M.		19					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER		22b DATE SIGNED					
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER		July 7, 1968					
Charles W. Trader, M.D., 302 Market St., Pocomoke, Worcester, Md.			DEPUTY MEDICAL EXAMINER							
23a BURIAL CREMATION REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR PLACE		23d LOCATION (City or Town) (County) (State)			
Burial			7-4-1968		Remson Methodist		Pocomoke - Wor. - Md.			
24 FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Robert H. Watson Pocomoke City, Md.					JUL - 8 1968		Charles Judge			

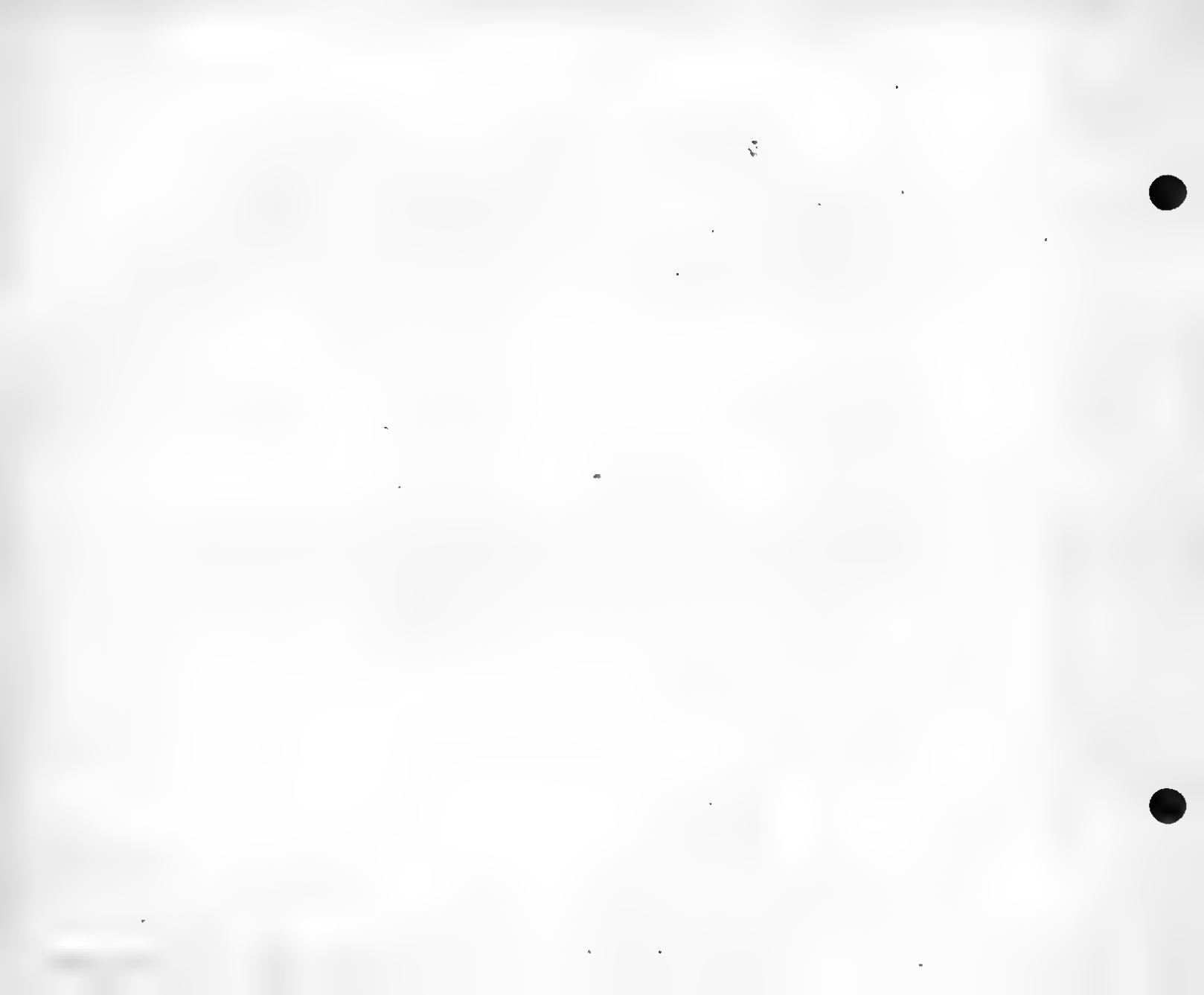
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print) <u>William J. Neubert</u>										2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <u>7</u> Day <u>30</u> Year <u>1968</u>		2b HOUR <u>M</u>					
3 SEX <u>M</u>		4 RACE <u>W</u>		5 DATE OF BIRTH <u>3-20-14</u>		6 AGE (In years last birthday) <u>54</u> YRS		7 UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		8 IF UNDER 24 HRS HOURS <u>0</u> MIN <u>0</u>		2c DATE PRONOUNCED DEAD Month <u>7</u> Day <u>30</u> Year <u>1968</u>		2d HOUR <u>1:30</u> M			
7a BIRTHPLACE (State or foreign country) <u>Delaware</u>				7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH <u>Worcester</u>					
10 CITY OR TOWN OF DEATH <u>Ocean City, Md</u>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ocean City, Md. Hospital</u>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY <u>Sea Fish</u>					
3a USUAL RESIDENCE (Where deceased lived, if not in hospital, residence before admission) STATE <u>MD</u>				13a CITY OR TOWN <u>Ind.</u>				13b INSIDE CITY, MTS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13c STREET AND NUMBER <u>516 Epsom Rd</u>					
14 FATHER'S NAME First <u>Frank</u> Middle <u>Neubert</u> Last <u>Neubert</u>						15 MOTHER'S MAIDEN NAME First <u>Sara</u> Middle <u>Ruby</u> Last <u>Ruby</u>											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16b SOCIAL SECURITY NO <u>2nd World War</u>						17 INFORMANT <u>Wife (Theresa)</u> ADDRESS <u>516 Epsom Rd</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>														<u>Immediate</u>			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Thrombosis</u>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
DUE TO OR AS A CONSEQUENCE OF (c) <u></u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201 none</u>																	
19a DATE OF OPERATION <u>8/3/68</u>						19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <u></u>						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u></u>				21b TIME OF INJURY Month, Day, Year <u>19</u>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u></u>				21f LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u>									
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Charles E. Jones</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b DATE SIGNED <u>July 2/1968</u>					
EXAMINER'S NAME (Type) <u></u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
						ADDRESS (Street, city, town, or county) <u></u>											
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b DATE <u>8/3/68</u>				23c NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>				23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>					
24 FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> ADDRESS <u>3331 Brehms Lane</u>						25a REC'D BY REG STRAR <u>AUG 2 1968</u>				25b REG STRAR'S SIGNATURE <u>Charles Jones</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-1-68
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

20825

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR		
GEORGE WASHINGTON PERDUE						Month	Day	Year	4:30 P.M.		
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		December 22, 1887		80 YRS		MONTHS	DAYS	HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				WORCESTER Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUA. OCCUPAT. ON (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Berlin			Berlin Nursing Home			Retired Farmer			Farming		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Maryland			Wicomico		Parsonsborg		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt. 2		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
John James B. Perdue			Hester Ennis								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT (Son) Address						
No			214-36-5005		Mr. Elton E. Perdue, Parsonsborg, Maryland Rt. 2						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u>										2 days	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Facial Neuralgia</u>										?	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senility</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
491X											
9a DATE OF OPERATION			9b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State					
						6/15 1968, to 7/1/68, 1968					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/15</u> , 19 <u>68</u> , to <u>7/1/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/1/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
<u>Clifford E. Schott M.D.</u>						JULY 3 / 1968					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Dr. Clifford E. Schott						314 N. Main Street, Berlin, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			July 5, 1968		Bethel Cemetery		Walston, Wicomico, Maryland				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
						JUL - 8 1968			<u>Charles Judge</u>		
HOLLOWAY & COMPANY, SALTSBURY, MARYLAND											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

10826

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301-W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10032

1 DECEASED-NAME (Type or print) PRESTON			First Middle Last GEORGE POWELL			2a DATE OF DEATH Month Day Year July 11 1968			2b HOUR 2:10 PM								
3. SEX Male			4 RACE White			5. DATE OF BIRTH July 9, 1921			6 AGE (In years last birthday) 47 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH WORCESTER Md								
10. CITY OR TOWN OF DEATH Berlin			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.D.#2, Stephen Decatur Rd			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer			12b KIND OF BUSINESS OR INDUSTRY none								
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b COUNTY Worcester			13c CITY OR TOWN Berlin			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER R.D.#2, Stephen Decatur Rd					
14. FATHER'S NAME First Middle Last Edward Powell			15 MOTHER'S MAIDEN NAME First Middle Last Emma A. Powell			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes			16b SOCIAL SECURITY NO (if yes give war or dates of service) War II 212-16-1354			17 INFORMANT (Father) Address R.D.#2, Box 91 Mr. Edward Powell, Berlin, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> 4107 DUE TO, OR AS A CONSEQUENCE OF, <u>A.S.H.D.</u> (b) <u>10 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Emphysema</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1964</u> to <u>7/11/1968</u> , that (I) (we) last saw the deceased alive on <u>7/9/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Frank E. Gantz MD</u>			22c. DATE SIGNED July 13/1968			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (Type) Dr. Frank E. Gantz			22e. ADDRESS 5 Bay Street, Berlin, Maryland														
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE July 13, 1968			23c. NAME OF CEMETERY OR CREMATORY Parsons Family Cemetery			23d. LOCATION (City or Town) (County) (State) Pittsville, Wicomico, Maryland								
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND			ADDRESS			25a REC'D BY REGISTRAR JUL 16 1968			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

10827		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10835	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	
Elizabeth Jane					Stuffer	July 11 1968	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
Female		White		Oct. 15, 1860		107 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH	
PENNSYLVANIA		U.S.A.				Worcester Md.	
1d. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
Stockton			Holland Nursing Home			HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND			WORCESTER		POCOMOKE		R.F.D. 1
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last				
- UNKNOWN -			- UNKNOWN -				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address		
No			NONE		MRS STELLA G'RAY, LINDICUM HTGS, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACIATIN + INANITION</u> <u>727.8</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>757.8</u> (b) <u>SEWILITY</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 MONTHS</u> <u>7 YRS</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>ANKYLOSED HIP + KNEE + ANKLE</u> <u>50WTS</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>7-1-63</u> , 19 <u>63</u> , to <u>7-11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-5-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED					
<u>Robert C. La Mar</u>		<u>7-11-68</u>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Robert C. La Mar, M.D.		104 Bay St Snow Hill, Md 21863					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		7-13-1968		WHATCOAT METHODIST		SNOW HILL - WOR. - MD.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert H. Watson		DATE JUL 15 1968		J. Charles Judge			

1951-52, 1952-53, 1953-54, 1954-55, 1955-56, 1956-57, 1957-58, 1958-59, 1959-60, 1960-61, 1961-62, 1962-63, 1963-64, 1964-65, 1965-66, 1966-67, 1967-68, 1968-69, 1969-70, 1970-71, 1971-72, 1972-73, 1973-74, 1974-75, 1975-76, 1976-77, 1977-78, 1978-79, 1979-80, 1980-81, 1981-82, 1982-83, 1983-84, 1984-85, 1985-86, 1986-87, 1987-88, 1988-89, 1989-90, 1990-91, 1991-92, 1992-93, 1993-94, 1994-95, 1995-96, 1996-97, 1997-98, 1998-99, 1999-00, 2000-01, 2001-02, 2002-03, 2003-04, 2004-05, 2005-06, 2006-07, 2007-08, 2008-09, 2009-10, 2010-11, 2011-12, 2012-13, 2013-14, 2014-15, 2015-16, 2016-17, 2017-18, 2018-19, 2019-20, 2020-21, 2021-22, 2022-23, 2023-24, 2024-25, 2025-26, 2026-27, 2027-28, 2028-29, 2029-30, 2030-31, 2031-32, 2032-33, 2033-34, 2034-35, 2035-36, 2036-37, 2037-38, 2038-39, 2039-40, 2040-41, 2041-42, 2042-43, 2043-44, 2044-45, 2045-46, 2046-47, 2047-48, 2048-49, 2049-50, 2050-51, 2051-52, 2052-53, 2053-54, 2054-55, 2055-56, 2056-57, 2057-58, 2058-59, 2059-60, 2060-61, 2061-62, 2062-63, 2063-64, 2064-65, 2065-66, 2066-67, 2067-68, 2068-69, 2069-70, 2070-71, 2071-72, 2072-73, 2073-74, 2074-75, 2075-76, 2076-77, 2077-78, 2078-79, 2079-80, 2080-81, 2081-82, 2082-83, 2083-84, 2084-85, 2085-86, 2086-87, 2087-88, 2088-89, 2089-90, 2090-91, 2091-92, 2092-93, 2093-94, 2094-95, 2095-96, 2096-97, 2097-98, 2098-99, 2099-00, 2100-01, 2101-02, 2102-03, 2103-04, 2104-05, 2105-06, 2106-07, 2107-08, 2108-09, 2109-10, 2110-11, 2111-12, 2112-13, 2113-14, 2114-15, 2115-16, 2116-17, 2117-18, 2118-19, 2119-20, 2120-21, 2121-22, 2122-23, 2123-24, 2124-25, 2125-26, 2126-27, 2127-28, 2128-29, 2129-30, 2130-31, 2131-32, 2132-33, 2133-34, 2134-35, 2135-36, 2136-37, 2137-38, 2138-39, 2139-40, 2140-41, 2141-42, 2142-43, 2143-44, 2144-45, 2145-46, 2146-47, 2147-48, 2148-49, 2149-50, 2150-51, 2151-52, 2152-53, 2153-54, 2154-55, 2155-56, 2156-57, 2157-58, 2158-59, 2159-60, 2160-61, 2161-62, 2162-63, 2163-64, 2164-65, 2165-66, 2166-67, 2167-68, 2168-69, 2169-70, 2170-71, 2171-72, 2172-73, 2173-74, 2174-75, 2175-76, 2176-77, 2177-78, 2178-79, 2179-80, 2180-81, 2181-82, 2182-83, 2183-84, 2184-85, 2185-86, 2186-87, 2187-88, 2188-89, 2189-90, 2190-91, 2191-92, 2192-93, 2193-94, 2194-95, 2195-96, 2196-97, 2197-98, 2198-99, 2199-00, 2200-01, 2201-02, 2202-03, 2203-04, 2204-05, 2205-06, 2206-07, 2207-08, 2208-09, 2209-10, 2210-11, 2211-12, 2212-13, 2213-14, 2214-15, 2215-16, 2216-17, 2217-18, 2218-19, 2219-20, 2220-21, 2221-22, 2222-23, 2223-24, 2224-25, 2225-26, 2226-27, 2227-28, 2228-29, 2229-30, 2230-31, 2231-32, 2232-33, 2233-34, 2234-35, 2235-36, 2236-37, 2237-38, 2238-39, 2239-40, 2240-41, 2241-42, 2242-43, 2243-44, 2244-45, 2245-46, 2246-47, 2247-48, 2248-49, 2249-50, 2250-51, 2251-52, 2252-53, 2253-54, 2254-55, 2255-56, 2256-57, 2257-58, 2258-59, 2259-60, 2260-61, 2261-62, 2262-63, 2263-64, 2264-65, 2265-66, 2266-67, 2267-68, 2268-69, 2269-70, 2270-71, 2271-72, 2272-73, 2273-74, 2274-75, 2275-76, 2276-77, 2277-78, 2278-79, 2279-80, 2280-81, 2281-82, 2282-83, 2283-84, 2284-85, 2285-86, 2286-87, 2287-88, 2288-89, 2289-90, 2290-91, 2291-92, 2292-93, 2293-94, 2294-95, 2295-96, 2296-97, 2297-98, 2298-99, 2299-00, 2300-01, 2301-02, 2302-03, 2303-04, 2304-05, 2305-06, 2306-07, 2307-08, 2308-09, 2309-10, 2310-11, 2311-12, 2312-13, 2313-14, 2314-15, 2315-16, 2316-17, 2317-18, 2318-19, 2319-20, 2320-21, 2321-22, 2322-23, 2323-24, 2324-25, 2325-26, 2326-27, 2327-28, 2328-29, 2329-30, 2330-31, 2331-32, 2332-33, 2333-34, 2334-35, 2335-36, 2336-37, 2337-38, 2338-39, 2339-40, 2340-41, 2341-42, 2342-43, 2343-44, 2344-45, 2345-46, 2346-47, 2347-48, 2348-49, 2349-50, 2350-51, 2351-52, 2352-53, 2353-54, 2354-55, 2355-56, 2356-57, 2357-58, 2358-59, 2359-60, 2360-61, 2361-62, 2362-63, 2363-64, 2364-65, 2365-66, 2366-67, 2367-68, 2368-69, 2369-70, 2370-71, 2371-72, 2372-73, 2373-74, 2374-75, 2375-76, 2376-77, 2377-78, 2378-79, 2379-80, 2380-81, 2381-82, 2382-83, 2383-84, 2384-85, 2385-86, 2386-87, 2387-88, 2388-89, 2389-90, 2390-91, 2391-92, 2392-93, 2393-94, 2394-95, 2395-96, 2396-97, 2397-98, 2398-99, 2399-00, 2400-01, 2401-02, 2402-03, 2403-04, 2404-05, 2405-06,

[Faint handwritten notes and signatures are visible at the bottom of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10828										10836									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Annie H. Wells					2a. DATE OF DEATH Month July Day 15 Year 1968					2b. HOUR 8P M									
3. SEX Female			4. RACE White			5. DATE OF BIRTH July 7, 1888			6. AGE (In years last birthday) 80 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN					
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Worcester Md.										
10. CITY OR TOWN OF DEATH Whaleyville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Worcester			13c. CITY OR TOWN Whaleyville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER no #							
14. FATHER'S NAME First Elijah Middle Hamblin Last Hamblin					15. MOTHER'S MAIDEN NAME First Elizabeth Middle Beauchamp Last Beauchamp														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) xx (If yes give war or dates of service) xx			16b. SOCIAL SECURITY NO. 214-46-4611			17. INFORMANT Address Thomas I. Wells Whaleyville, Md													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 428X IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO, OR AS A CONSEQUENCE OF (b) 2 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9222 rheumatoid arthritis																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from 1960 , 19 7-15 , 19 68 , that (I) (we) last saw the deceased alive on 7-15 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Frank Lewis										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 7-16-68						
22d. PHYSICIAN'S NAME (Type) Frank Lewis					22e. ADDRESS Willards Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 7/18/68		23c. NAME OF CEMETERY OR CREMATORY Dale			23d. LOCATION (City or Town) (County) (State) Whaleyville Md.											
24. FUNERAL DIRECTOR Peter Whaley Whaleyville Md.					25a. REC'D BY REGISTRAR DATE JUL 17 1968			25b. REGISTRAR'S SIGNATURE Charles Judge											

